The Manitoba Medical Association Review

ANNUAL MEETING
ROYAL ALEXANDRA HOTEL
WINNIPEG, SEPT. 10-11-12

IN AFFILIATION WITH
THE CANADIAN MEDICAL ASSOCIATION
THE BRITISH MEDICAL ASSOCIATION

AUGUST
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The Manitoba Medical Association Review

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Volume XIV., No 8

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The Manitoba Medical Association

CLINICAL MEETINGS

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At Brandon General Hospital—
2nd Wednesday at 12.30 p.m.

At Brandon Hospital for Mental Diseases—
Last Thursday. Supper at 6.30 p.m.
Clinical Session at 7.30 p.m.

At Children's Hospital—
1st Wednesday.
Luncheon at 12.30 noon.
Ward Rounds 11.30 a.m. each Thursday.

At Grace Hospital—
3rd Tuesday.
Luncheon at 12.30 p.m.
Discussion of Obstetrical Cases will form a large part of the clinical hour.

At Misericordia Hospital—
2nd Tuesday at 12.30 p.m.

At St. Boniface Hospital—
2nd and 4th Thursdays.
Luncheon at 12.30. Meeting at 1.00 p.m.
Ward Rounds 11.00 a.m. each Tuesday.

At St. Joseph's Hospital—
4th Tuesday.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.

At Victoria Hospital—
4th Friday.
Luncheon at 12.00. Meeting at 1.00 p.m.

At Winnipeg General Hospital—
1st and 3rd Thursdays.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.
Ward Rounds 10.00 a.m. each Thursday.
Pathological Conference at Medical College at 9.00 a.m. Saturday during College Term.

Winnipeg Medical Society—
3rd Friday, Medical College, 8.15 p.m.
Session: September to May.

Eye, Ear, Nose and Throat Section—
1st Monday at 8.15 p.m., at 101 Medical Arts Bldg.

Clinical Section

* THE AETIOLOGY OF NEUROSIS

By

G. L. ADAMSON, M.D. (Man.), M.R.C.P. (Ed.)

Assistant Physician, Winnipeg General Hospital
Demonstrator in Medicine, University of Manitoba

PRESENT day ideas concerning the aetiology of the neuroses are the culmination of centuries of speculation and observation. The ancients ascribed the symptoms of hysteria to the abnormal wandering of the womb about the pelvis and abdomen. This theory met the requirements of their observations since they believed hysteria to occur only in women. The object of their treatment then was to induce the womb to return to its normal anatomical position. In order to do this they administered to their hysterical patients vile tasting drugs in the hope that the uterus would be thus disciplined, and return to its broad ligaments.

Chief amongst the drugs used by them was Valerian. It is interesting to note that this drug is still in general use today in the treatment of "functional disorders." Since Valerian is inert chemically and pharmacologically it is difficult to understand its continued use, since the theory of the ancients has long since been abandoned.

In the middle ages abnormal behaviour was ascribed to possession by the devil and psychotic and psychoneurotic people were either venerated as prophets and sages or else tortured and put to death. Today we have abandoned this concept concerning the causation of neurosis; but there are many who seriously advocate the lethal chamber for the psychotic, and there are many who look upon the neurotic as unworthy of consideration.

A few years ago all obscure disorders, and amongst them the neuroses, were supposed to be due to a functional disorder of the endocrine system. The popularity of this idea is beginning to wane since it has been discovered that neurotic people do not become well following the administration of orchic substance, thyroid, pituitary extract, adrenal cortex, or desiccated mammary glands.

Today we believe that the neuroses are *psychogenic* in origin. That is to say that they are due to disturbances in the psyche or mind. Moreover we believe them to be due to disturbances in the emotional life, while the intellectual functions are preserved or affected only secondarily.

The aetiological factors in the development of a neurosis may be spoken of as *predisposing* and *exciting*.

It is probable that symptoms occur only as the result of a combination of these factors. That is to say: an individual may be predisposed in certain ways to neurotic illness but he may escape such illness unless some exciting factor precipitates the symptoms. Conversely many people undergo the vicissitudes of a turbulent existence suffering many emotional insults, but yet since they are not predisposed to this particular kind of trouble they remain well.

The exciting factors are well known and are easily recognized. Everyone realizes that neurotic illnesses may be precipitated by a shock of any kind whether physical or emotional. Prolonged states of fear, possibly quite justified by the seriousness of the situation, may act as an exciting factor to the clinical picture of neurosis. Painful physical illness or prolonged physical illness frequently precipitates a neurosis, as we all know.

The experience of a severe physical injury may precede the clinical development of "functional" disorder. Anxiety for the future, regret for the past; envy and fear — these are the emotions which excite the appearance of symptoms. Let me again emphasize the fact that none of these exciting causes are sufficient to plunge an individual into neurotic illness unless there exists a potent predisposing factor. I wish to make this point clear as it has a very definite bearing upon treatment.

The predisposing factor or factors are of the greatest importance and only a realization of their characters can give an understanding of the nature of neurotic illness. Often the medical man while realizing the existence of the exciting cause fails to appreciate anything underlying it and therefore fails to understand the significance of his patient's symptoms.

It may well be that inherited defects are responsible for the predisposition to neurotic illness in certain individuals. Indeed in the past a bad hereditary background was regarded as the only or major predisposing cause. When this is so the prognosis is bad and treatment is of little avail. On the other hand, present day trends tend to minimize the hereditary element. The researches of Janet, Freud, Yung, Adler demonstrate how false it is to assume that neurotics are necessarily people of weak constitutions that have been inherited, or that they are people stigmatized from birth according to the Mendelian principle. The importance of acquired predisposing causes was first clearly stated by Freud, and treatment based on the concept of acquired predisposition has been his greatest contribution to medicine.

What is the nature of these acquired predisposing factors? This is a question which all who would treat "functional" disorders must make

**Clinical Lecture read at the Manitoba Medical College, Post-graduate Course, May, 1934.*

some attempt to answer. The soil from which the clinical syndrome springs is just as deserving of our curiosity as the rain of unfortunate events which excites it to bloom. The background of the patient's life is this soil.

The important element to determine in the life history of the patient is not whether he suffers mental conflict — for everyone does — but the nature of that conflict. In that unresolved conflict may be hidden from the knowledge of the patient, that is in that it may be unconscious, its discovery may be difficult.

I have mentioned two words which may bear some elucidation; they are "conflict" and the "unconscious." *Conflict* is that state in which two elements in one's being are antagonistic in relation to a given situation. Many of our secret desires conflict with what we feel to be worthy. We can then only attain these desires at the expense of some self respect. Which is one to sacrifice? Unless this situation can be resolved, that is to say, unless one thing or the other is done, then the conflict continues—and may continue even when action has been undertaken if such action be coupled with a sense of unworthiness. In such a case the whole situation has unpleasant associations. Contact with similar situations produces feelings of uneasiness in the individual, and unless these feelings can be expressed the emotional tension involved may lead to physical symptoms or loss of emotional stability, in the face of an excitant. May I illustrate such a case? Here is a man aged 45. Physically he is well. His complaint is that he has been *afraid* for the past week. This fear came on suddenly one night as he was falling to sleep. It is so bad that he cannot stay alone. He has never experienced anything like it before. How can one understand such a symptom? He is absolutely incapable of giving any reason for his fear. What are the predisposing and the exciting factors? Several conversations with the patient show that though he is highly successful in an economic way, and though he occupies a prominent position in the business world, he has had many emotional difficulties which have made him unhappy. He has never broken before, however. He is the youngest of three brothers. As a child he was self-conscious and had the habit of comparing himself unfavourably with others. He spontaneously tells of a feeling of inadequacy which has existed since his earliest years. It was a fear learned very early in his childhood — and it has prevented him from easy intercourse with those upon the same social level as himself. He stated spontaneously that he could feel at ease only in the presence of those he considered inferior. After marriage fifteen years before he realized that he was not satisfied with the sexual restrictions placed upon him by that state. His self respect and fear of the opinion of society were antagonistic elements in him so far as his wish was concerned. Nevertheless he had had several extra marital experiences. But always with the feeling of guilt and fear of detection. They had always been when he was away from home until the last one. A few days before the onset of his symptom he had been very nearly detected while with his paramour. He had been badly frightened by this experience. So much so that he decided to end the affair. In fact he was not sure that he had escaped detection. The memory of this undignified and disgraceful experience was with him constantly though he tried to keep it out of his mind. He goes home to bed; is nearly asleep when he is awakened by a terrific feeling of terror. He does not connect it with his recent experiences. He does not understand it.

These are the points this case seems to illustrate:

(1) The existence of conflict over a long period which has made this man secretly sensitive and guilty. This conflict prepared the way for some emotional disorder and can thus be spoken of as a *predisposing cause.*

(2) Action was taken in response to his wish. But such action as hurt his self respect and made him feel even more unworthy.

(3) Nothing happened — *i.e.*, no incapacitating symptoms appeared until something happened to precipitate a crisis — *namely*, he was badly frightened by near discovery. This episode, this final blow to his self respect proved the last straw. But I hope you see how inadequate the exciting cause would have been to produce such an acute illness in an individual who had always found his adjustments to the various circumstances of his life relatively easy; in one who had learned in childhood the fortunate habit of mind which leads to a placid and philosophical attitude toward himself and toward life.

The exciting cause of neurotic illness as given by the patient is usually just as inadequate when considered alone as that frequently given by the victim of some physical disease. A man tells his physician that his pneumonia developed the day after he stood on the corner of Portage and Main in a cold north wind. The patient gives undue importance to his exposure. His predisposition to the illness is not realized by him but it must be understood by his physician. That he succumbs to pneumonia at that time must have had something to do with his general health. And in neurotic illness the background of the patient's general emotional adjustment is just as important.

I have said that very commonly antagonistic forces in a personality may war without the individual being aware of what is going on. This internal conflict which is shut off from the conscious mind, which takes place behind the scenes as it were, may act as a potent predisposing factor in neurotic illness. In such cases, while the patient is unaware of the conflict in the *unconscious* part of his mind, this conflict expresses itself in the form of symptoms of various kinds. When asking the patient about his worries and

troubles the physician may be met by the statement "I have no worries, I am just nervous and I don't know why." This is the kind of thing which makes psychotherapy difficult because it makes the physician think that his patient is deliberately witholding information and is refusing to co-operate. Unless one understands that the patient may actually be telling the truth it is hard to maintain the very necessary equanimity and friendliness required in such cases. When no adequate cause for the trouble can be given by the patient it is necessary to seek it by perhaps prolonged exploration of the person's life. Only then may conflict around some forgotten incident be revealed. Although the incident is forgotten the conflict continues and when some exciting situation occurs symptoms appear. May I illustrate my meaning by describing a very simple instance. A twenty-five-year-old school teacher complained because she seemed unable to resume her work following an attack of "flu." She had recovered from the infection but continued to lie about the house. She wept copiously on the slightest pretext, was extremely irritable and complained of weakness, insomnia and headache. She had had many similar periods of agitation over the past ten years.

Physical examination revealed no abnormalities. She was at first suspicious and it was difficult to get her confidence. Soon she began to co-operate. Here are some of the potent predisposing factors in the order in which they were revealed:

(1) Her mother, who was very "nervous," constantly nagged and advised her, thus irritating her beyond measure.

(2) She was afraid of her work, afraid of her pupils not making a good showing; afraid she would not be able to control them.

(3) In the past year she had been upset over a disappointing love affair. This contributed very definitely to her loss of self confidence.

(4) A younger sister was the favourite of the family, was engaged to be married and the patient already saw herself as a neglected old maid.

(5) At the age of twelve she was the victim on several occasions of a sexually perverted relative. These experiences taught her to fear men and served to make her very self conscious. Following these experiences she had masturbated a few times. This habit increased her already growing tendency to think about herself in an apprehensive way, and she began to fear that she had contracted some dreadful disease and that she was abnormal sexually. The sexual experience had been forgotten and was recalled only with difficulty, but the vague fears concerning herself had persisted over many years. She was, as I have said, full of doubts concerning her physical and mental well being. Is it any wonder that periodically this inward turmoil should become too much for her to stand—especially when she was run down and feeling poorly physically? At such times the load of her private fears, about which she could talk to no one, became too great and her emotional control was too weak to keep her facing all the petty annoyances of life. The outbreak of symptoms at such times represented a simple surrender to the spiritual struggle going on within her. Her symptoms served to "close the door" on the problems that were really worrying her. By virtue of her neurotic illness she was enabled to withdraw as it were from the necessity of having to face all the petty troubles which enhanced her feeling of inadequacy and doubt.

This is the meaning of all neurotic illness. It is an unconscious attempt to compensate for fears or to escape conscious or unconscious conflict. Consciously the patient is far from desiring to be ill, but *not* to be ill means to face uncomfortable, painful, difficult experiences. The terrors of the past have made him fearful of the future, and the resultant over-wrought emotional state inevitably has its effect upon organic functions. The patient becomes aware of his body. He realizes that he is tiring easily, that he has difficulty with his digestion, that he has become subject to headaches, etc. Such symptoms serve to fix his attention more and more upon himself. He becomes convinced that his past sins are overtaking him. He is now ripe for the ministrations of the quack, the Christian Scientist, the Osteopath. He goes to his physician and is told that there is nothing wrong. What can he do but break under such an emotional strain? He conceives himself as facing the world heavily handicapped. How can he hope to succeed? It is easy enough to say his illness is imaginary but it is real enough to him who has suffered for many years a spiritual unrest, an emotional sensitiveness and intensity which no phlegmatic person can fully comprehend. The exciting factor is relatively unimportant. To understand the illness one must see deeper.

Editorial and Special Articles

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Editorial or other opinion expressed in this Review is not necessarily sanctioned by the Manitoba Medical Association.

MEDICAL SERVICES FOR RELIEF CASES

DURING the last few weeks, Dr. E. S. Moorhead, Chairman of the Committee on Sociology of the Manitoba Medical Association, addressed a district meeting of the Municipal Councillors at Dauphin. He gave a general outline of the situation with regard to medical service for relief cases and the plans that have been made in other municipalities. He is to address the medical society at Shoal Lake as well.

The Committee on Sociology has been advised that so far as the working out of the present plan in Winnipeg is concerned, the City Council are grateful for the co-operation which they have received from the medical profession. A monthly meeting of the medical referees of Greater Winnipeg is held, at which common problems are discussed.

There are, however, several points in connection with the medical relief work that the Committee wish to bring to the attention of the practitioners. It is emphasized again that doctors are not to give patients recommendations to carry to the medical referee. For example, if they consider that the patient should have an extra supply of milk, this recommendation should not be given verbally or in writing to the patient. Any such recommendation should be made in writing and *mailed* to the medical referee.

Some doubt has arisen as to the proper disposal of a case which has been chronic and which has suddenly become acute. It is pointed out that in such a case, any necessary treatment should be carried out under Clause 5 of the agreement, even if authorization for such treatment has been refused previously by the Medical Advisory Board. In other words, the doctor's first responsibility is to the patient.

It has been pointed out further that there has been some misunderstanding as to the type of case for which authorization for treatment will be given. It might be suggested that the general purpose of the medical service for citizens on relief be kept in mind. This service is purely an emergency measure and is intended primarily for acute and subacute cases. There apparently have been instances in which patients have applied for treatment for some condition of long standing which, although not comfortable, is not dangerous and authorization for the treatment of these cases has been withheld. It has been pointed out

that the other phases of the relief programme do not presume to restore the recipient of the relief to the same conditions of living to which he was accustomed, when he was employed. For example, the citizen who previously had lived in an eight-roomed house may have to be content with a smaller dwelling and he may have to be satisfied without many luxuries to which he was accustomed. In the same way the medical service is intended to cover cases which are acute or subacute and not necessarily supply a complete medical service. Instances have occurred where patients have applied for treatment for a condition which was not disabling and from which they have suffered for many years. It is obviously unfair to expect the other citizens who are paying for the unemployment relief to finance treatment for a condition for which the patient might well have paid when he was normally employed.

The medical service is intended to maintain each applicant in such condition as to enable him to carry on for the duration of the present emergency and to be the least possible burden on the community. It is not intended to include treatment for the relief of ailments or discomforts which are not disabling.

Some misunderstanding has arisen as to whether or not daily hospital visits will be paid for. It has been pointed out that these will be paid for only when the doctor in attendance is able to justify to the medical referee and the Medical Advisory Board the necessity for the frequent visits.

It has recently been reported in the press that the City Council have stated that unless the Provincial or Dominion Governments, or both, give them some financial aid, they will be unable to carry on providing medical services for relief cases. It has been further reported that they have suggested that the medical profession should bring pressure to bear on the Provincial and Dominion Governments to give financial assistance for the carrying on of the medical work.

These reports imply that it is the business of the medical profession to negotiate with the Provincial and Dominion Governments. The actual responsibility of these various bodies does not confirm this view. When the medical profession of Winnipeg first found they could no longer continue to provide, at their own expense, free medical services for all citizens who were unable to pay for it, they spent many months trying to find some governmental body that would admit responsibility for those in receipt of unemployment relief. They were finally obliged to realize that the various governing bodies would accept no responsibility other than that to which they are committed by the law. It is beyond dispute that, according to law, medical care for indigent persons is a responsibility of the various municipal governing bodies. It follows therefore, logically, that the medical profession is forced to negotiate with the municipal bodies and not with Provincial or Dominion Governments. While no doubt the profession, as indicated by Dr. Moorhead, will be willing to co-operate in any way with the Council of the City of Winnipeg in placing the facts of the situation before either the Provincial or Dominion Governments, the responsibility for asking for and obtaining any necessary financial aid is quite definitely not only the responsibility but the privilege of the City Council.

In this connection it might be worth while quoting from a letter received by the Winnipeg

Medical Society on January 25th, 1934, from the Premier of Manitoba, the Honorable Mr. John Bracken:

". . . . the problem now rests in its original position, namely, one in which the immediate responsibility lies where it has always been, that is, with the municipalities affected.

"Nevertheless I may add that should any Municipality in financial difficulties be unable to pay for the cost of proper medical attention to those on relief, any proposal advanced by such Municipality will receive the sympathetic consideration of the Provincial Government, and such action as the needs of the situation and the finances of the Government permit."

It is also of interest to quote from a letter sent to the Premiers of the various Provinces by the Prime Minister of Canada, the Right Honorable Mr. R. B. Bennett, on December 12th, 1933. A copy of this letter was forwarded to the Canadian Medical Association and by them to the Winnipeg Medical Society, after a conference between the Canadian Medical Association and the Prime Minister.

"A delegation representing the Canadian Medical Association met me some weeks ago and urged the desirability of the Federal Government providing a portion of the cost of medical aid for those receiving relief in the various Provinces.

"I pointed out to the delegation that I assumed the Provinces would continue to discharge their obligations to their citizens, but if, from time to time, representations were made in respect to individual communities where it was found that the burden was unduly onerous, the Federal Government would sympathetically consider each case upon its merits and determine whether or not, on the facts stated, it would be warranted in making a contribution to assist the Provinces to discharge their normal responsibilities regarding medical and hospital care and treatment."

For over two years the medical profession provided, at its own expense, medical services for people on relief. Eventually the Council of the City of Winnipeg proposed a plan for medical services for relief cases, which was accepted by the Winnipeg Medical Society and which has, from February 22nd, 1934, worked in a very satisfactory manner. In the working of this plan, the medical profession agreed voluntarily on their own suggestion, to bear one-half the expense of the plan by doing the work for one-half of the usual fees. If the City Council believe that the Provincial Government or the Dominion Government should contribute towards the cost of the scheme, it is quite definitely their responsibility to make the necessary representations to these governments. However, the medical profession will no doubt be quite willing now, as in the past, to assist in any way that the City Council may suggest.

—C. W. MacC.

INSURANCE CERTIFICATES

In July, 1933, an agreement was reached between the Western Canada Insurance Underwriters' Association and the Manitoba Medical Association whereby the insurance companies, while stating they could not assume the responsibility of payment for production of medical certificates, declared they were prepared to pay for the certificates provided the doctors, when completing the certificates, endorsed thereon an authority signed by the claimant for the payment of the fee by the company. In such an instance the insurance company would see that the stipulated fee was deducted from the amount payable to the claimant.

When doctors, therefore, are asked to fill in medical certificates they may either collect direct from the insured person or have the insured person sign a statement authorizing the company to deduct the amount of the medical fee for filling in the certificate from the amount due him by the company.

—R. B. M.

TENTATIVE PROGRAMME OF THE ANNUAL MEETING

The following is the tentative programme of the Annual Meeting of the Manitoba Medical Association to be held September 10, 11 and 12:—

MONDAY, SEPTEMBER 10th

9.00 a.m.—Registration at the Medical College.

10.00 a.m.–12.15 p.m.—Pathological Clinical Conference, Medical College.

12.30 p.m.—Luncheon at the Royal Alexandra Hotel. Luncheon speaker–Dr. E. S. Moorhead.

2.30 p.m.– 5.00 p.m.—Symposium–"Pain in the Upper Right Abdomen." It is expected that the following will take part in this symposium:– Dr. B. R. Kirklin, Dr. Donald C. Balfour, of Mayo Clinic, Rochester, Minnesota.

6.30 p.m.—Alumni Dinner. Guest speaker (It is hoped that we will have Doctor Louis B. Wilson, of Mayo Clinic, Rochester, Minnesota, as the guest speaker for this dinner).

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TUESDAY, SEPTEMBER 11th

9.00 a.m.–12.15 p.m.—Clinical Papers at the Manitoba Medical College.

12.30 p.m.–Luncheon and Annual Meeting. Presidential Address by Doctor J. C. McMillan.

3.00 p.m.– 4.00 p.m.—Scientific Programme.

4.00 p.m.– 5.00 p.m.—Answering Questions from the Question Box.

6.30 p.m.—Annual Dinner and Dance at the Royal Alexandra Hotel.

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WEDNESDAY, SEPTEMBER 12th

9.00 a.m.–12.00 p.m.—Scientific Programme.

2.00 p.m.—Annual Golf Tournament.

The present arrangements would indicate that the following subjects will be discussed during the scientific sessions:—Arthritis, Squint, Common Errors in Diagnosis of Children, Headache, Fractures of the Elbow, Disseminated Sclerosis, Heart Disease, Eczema in Childhood, Modern Treatment of Prostatic Hypertrophy, and Treatment of Occiput Posterior Position.

It will be noticed that all the scientific discussions are to be held at the Manitoba Medical College.

We wish to draw to the attention of those who are likely to be present at this meeting that at the registration desk there will be a Question Box. Any doctor who has any problem that he would like to have answered should present the problem in writing and drop it into the Question Box. It does not need to be signed or identified in any way but it will be answered by some one qualified to give intelligent information on the question asked. Please be sure and bring your problems with you for the Question Box.

There will be the usual social functions for the ladies. We are sure that every doctor who brings his lady with him can be assured that she will have an enjoyable three days.

THEY WILL NOT PASS

By ALIX THORN

THESE things–they will not pass,
And this I know:
The season's shine and shower,
Young buds that blow,
The garden's perfect peace,
A summer day,
The joy that comrades find
In forest way,

* * *

The treasure sunset spills
O'er mountain crest,
The moon which stately sails
To find its rest,
The courage that can meet
What years may send,
The understanding love
In smile of friend.

MANITOBA MEDICAL ASSOCIATION

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ANNUAL MEETING

WINNIPEG

SEPT. 10-11-12

1934

Department of Health and Public Welfare

CARCINOMA OF THE CERVIX UTERI

By

J. D. McQUEEN, D.S.O., M.D., C.M. (Man.)
F.R.C.S. (C.)

Associate Gynaecologist, Winnipeg General Hospital
Associate Professor of Obstetrics and Gynaecology
University of Manitoba

A clinical lecture given at the Manitoba Medical College Post-Graduate Course May, 1934. This article is also sponsored by the Cancer Relief and Research Institute.

WITH the space at our disposal it will be impossible to cover this subject in detail, but an effort will be made to place before you what are considered the more essential phases requiring consideration in the causes, diagnosis, and treatment. Only by a wider understanding of the anatomical and histological features of the tissues affected and the principles involved in present day treatment can we hope to improve our efforts in diagnosis, management and treatment. For, in spite of great professional effort during the last two decades, carcinoma of the cervix still claims a high percentage of victims.

To properly appreciate the organs likely to be involved with extension of this disease and likely to be impaired during the treatment, we must have an accurate mental picture of the contents of the pelvis — particularly is this so when considering the relationship of the bladder, rectum and ureters, to the cervix. The lymphatic drainage of the cervix, after concentrating in a mesh of channels in the parametrial tissue, passes outward by two main channels along the uterine vessels, one below the ureter to the hypogastric or internal iliac glands, while the other runs above the ureter outward and upward to the external iliac group. The posterior portion of the cervix is drained through lymph channels which run backwards and upwards through the uterosacral ligaments to the sacral glands. The epithelial lining of the vagina and endocervix are both originally derived from muellerian epithelium, but as you know, in adult life, the vaginal mucous membrane is stratified squamous epthelium or epidermoid in type, while the cervical canal is lined with cuboidal epithelium in which are many racemose glands which penetrate deeply into the connective tissue of the cervix. Carcinoma of the cervix may originate from either of these types of epithelium. If from the former, it is called squamous celled, or epidermoid carcinoma. If from the latter, it is called adenocarcinoma.

Epidermoid carcinoma is by far the most common and displays a variety of types which have an important bearing upon the prognosis and treatment. Depending upon the predominating type of cell in the new growth, the tumour is placed in one of four grades. If the predominating cells are clearly defined, mature, and mitosis is practically absent, it is placed in Grade 1. If, on the other hand, the cells are poorly outlined, undifferentiated, anaplastic, embryonic in character, with marked mitosis present, it is placed in Grade 3 or 4. Grade 1 is slow growing and radio-resistant, while Grade 4 is rapidly growing, very malignant but radio-sensitive. Adenocarcinoma has not yet been graded in a manner acceptable to all organized workers but in most cases its degree of malignancy is about equal to Grade 2 of the epidermoid type, and clinically behaves in a similar manner.

Carcinoma of the cervix is classified topographically into:

1. *Everting*—proliferating, cauliflower or papillary, fungating.

and

2. *Inverting*—infiltrating, nodular, ulcerative, parenchymatous.

Another classification is the degree to which the disease has progressed.

Stage 1. Disease limited to the cervix.

Stage 2. Disease extended to lower segment or nearby vaginal wall.

Stage 3. Disease extended to parametrium and broad ligament.

Stage 4. Has produced widespread fixation and metastisis.

Clinical aspects worth keeping in mind: Carcinoma of the cervix develops almost entirely in parous women, usually between the ages of 35 and 50 years and most frequently in those who give a history of having a leucorrhoea for years. A cancer family history is not infrequent.

The signs and symptoms are leucorrhoea, bleeding and pain. In the early stages there may be no symptoms, but a leucorrhoea, particularly if there has been a change in its character such as increase in the amount, becoming more irritating, more watery, with odor or tinged with blood, in a woman 35 or over, should be thoroughly investigated. Bleeding may be noticed as a staining of the discharge, spotting after mechanical irritation, *i.e.*, bowel movement, intercourse or pelvic examination, or it may take the form of a metrorrhagia. Pain, unfortunately, is a late symptom and only appears after there is secondary infection or wide spread metastisis. Anemia, chachexia, emaciation, fever and fistulae appear in the later stages. Diagnosis of carcinoma of the cervix in the everting type can usually be made clinically, but biopsy only will confirm a diagnosis in the inverting type. If any doubt exists as to diagnosis of cervical erosion, eversion or cystic degeneration, there should be

no hesitation in securing a specimen for biopsy. Only by securing a specimen from the cervical canal will some cases be diagnosed, as occasionally the cervix though seemingly intact to the naked eye, is a mere shell with considerable extension of disease upwards. In securing a section for biopsy it should include the mucocutaneous border in early cases and the edge of the growth in those more advanced. The securing of the biopsy specimen by electric loop is preferable, but if removed by punch or knife the raw surface should at once be cauterized and thus lessen the chance of spread of malignant cells.

Schiller's test for early malignancy of the vaginal portion of the cervix has come into prominence lately. It consists of allowing lugol's solution to remain in contact with the cervix for a minute—healthy tissue becomes a dark mahogany brown while cancerous tissue or precancerous areas (leucoplacia) do not stain. Epithelium scraped in these suspicious areas frequently shows malignant changes. This method is now receiving wide application in suitable cases in both Europe and America.

Prognosis depends to a marked degree upon the stage into which the disease must be placed when the patient presents herself for treatment. The grade into which the predominating cells place the tumor, you will readily understand, also affects the expected outcome.

Preventive treatment or prophylaxis should be foremost in our minds at all times. It seems fairly well proven that chronic irritation of the cervix is the only known predisposing cause of carcinoma of the cervix. In the nulliparous woman there is a fairly well defined mucocutaneous border between the squamous celled vaginal portion of the cervix and the endocervix but after parturition or rough instrumentation, abrasions occur and at these points a continual struggle between the two types of cells result. Anything that will stimulate growth or overgrowth on the part of either of these waring cells may also stimulate them to the extent of assuming a malignant tendency. Eversion, lacerations, erosions, a stagnant infected leucorrhoeal discharge, displacements resulting in abnormal friction on the cervix, or poor drainage of any portion of the genital tract, all cause a chronic irritation of this dangerous area. Timely treatment or repair of cervical lesions would prevent many cases later becoming malignant.

Treatment of carcinoma of the cervix today is radiation. With few exceptions the medical world believes that radium

treatment either alone, or combined with x-radiation, gives to the patient the best chance of permanent cure.

A few whose number is steadily diminishing still believe that in spite of the immediate mortality that the radical operation still is the treatment of choice. In a Stage 1 case of the Grade 1 type, surgery may still have a definite place, but how seldom does this favorable combination exist. Others believe that operation should follow radium treatment, but this procedure has proved disappointing. At most large centres of Europe and America, the application of radium to the cervix with deep x-ray treatments as an adjunct has been found to give the best results and they believe these results should improve as the technique of application improves, and with greater education of the profession and public to the danger of allowing suspicious symptoms to go uninvestigated.

Radium element is continually giving off Alpha, Beta and Gamma rays, in all directions. The caustic action of the Alpha, Beta or short rays have to be eliminated by screening, while it is the Gamma or penetrating rays that are made use of in the treatment of malignant tumors. These far-reaching rays seem to have a "destructive selectivity" for rapidly growing or immature cells — apparently the nucleoli of these immature cells are particularly susceptible to Gamma rays. Normal or fully developed cells are not affected to anything like the same degree. For this reason, new tumor cells, especially rapidly growing ones, can be destroyed without normal tissue around them being impaired, and isolated cancer cells well beyond the ocular boundaries of the tumor can be eliminated provided a correct dosage is used. Distance of cancer cells from the source of the Gamma rays rapidly diminishes the action of the rays, dense fibrous body tissue lessens the penetrating power of the rays also. With these points in mind our aim in the treatment of carcinoma of the cervix should be to administer a lethal dose of Gamma rays to all cancer cells whether they be in the cervix, uterine body, parametrial tissue or vaginal wall, keeping in mind at all times the proximity of the rectum, bladder and ureter.

From what has been said previously, it will be readily understood that the rapidly growing or very malignant type of cell will be more radiosensitive than the slow-growing one, *i.e.*, a Grade 3 or 4 cancer will respond more readily to radium treatment than a Grade 1 in the same stage. The stage into which the growth has been allowed to extend before giving treatment will naturally effect the placing and dosage of radium. Though clinically, no involvement of the parametrium can be demonstrated, I consider all cases, particularly the more malignant grades, should be treated as having parametrial involvement until proved otherwise.

The technique or methods of application of radium in carcinoma of the cervix are innumerable, but a few general principles are worthy of note. The interstitial method or insertion of needles containing radium element into cancerous growths of the cervix, and into the broad ligaments, is being abandoned to a great extent, and being replaced by methods which will give an evenly distributed cross-fire, not only upon the cervical growth, but also upon the paracervical tissue. This is accomplished by placing radium first in the uterine cavity and cervical canal, secondly in the lateral fornices, and thirdly against the end of the cervix. The dosage is measured in milligram or millicurie hours. The distribution of time over which this dosage should be given is still a matter of controversy. One school believes in a maximum initial dose. The French school, however, considers a single application of a small amount of radium, over a long period, is more likely to destroy any new cells than form over this long period. The Stockholm and London clinics take a middle course. Most authorities believe that radium must be augmented by deep x-ray to the pelvis through four parts in order to reach carcinoma cells in the sacral and iliac glands and in the outer portions of the broad ligament.

Radium element or radon may be used. Rubber and metal screening must be used to eliminate the local effects of the short and secondary rays, and to protect the bladder and rectum from an overdose of the penetrating rays. The bladder and rectum must be held as far away as possible by packing in the vagina.

Radium is by no means a harmless remedy,— local necrosis, fistulae, fatal infections, alarming anæmias, may and do result from injudicious dosage and application. Only by familiarity with, and attention to, the many details in the technique of application can these complications be avoided. Inadequate dosage, on the other hand, accomplishes little and brings the use of radium into disrepute. Cases treated by radiation must be kept under close observation and early local recurrences may frequently be successfully treated. Only those cases clinically free from recurrence after five years are considered cured.

With palliative treatment much can be accomplished to lessen the burden borne by the far-advanced cases.

During the last three years, I have had the privilege of treating most of the cervical cancers in the public wards of the Winnipeg General Hospital. My experience has been that in most cases the disease has spread beyond the cervix when admitted for treatment, but it has been possible, in most of these, to irradicate the malignancy from the cervix and uterus, but that the disease remained active and progressed in the broad ligaments — curiously enough more frequently in the left. Every effort was made to

overcome this defect by application of radium in the lateral fornices but without success. The x-ray seemed to retard but not eliminate growth in the broad ligaments. This observation was reported to our tumour group and now for nine months or a year the dosage of x-ray treatment has been markedly increased with, I believe, encouraging results. Well-conducted clinics report a five-year cure in about one in four of all cases presenting themselves for treatment.

Even with radium and x-ray at our disposal in the cure of carcinoma of the cervix, to lessen the number of deaths from this disease the most important facts for us as practising physicians to remember are:—

1. Simple postpartum treatments given to abrasions of the cervix at or near completion of involution will prevent much more serious infections at a later date. If lacerations and infections are found at any time, our duty is to eliminate these conditions either by local applications or operative treatment.

2. Without thoroughly examining the pelvic organs we must never be guilty of turning away patients who come complaining of leucorrhoea by simply ordering a vaginal douche.

3. We must not be satisfied with believing irregular bleeding at or about the menopause is due to the "change of life" until we have used every means at our disposal to exclude the presence of malignancy.

COMMUNICABLE DISEASES REPORTED — Urban and Rural —June, 1934. Occurring in the Municipalities of:—

Measles: Total 943 — Winnipeg 486, St. James 50, Norfolk North 50, Birtle Town 46, Fort Garry 25, Old Kildonan 23, Rapid City 23, St. Vital 23, Unorganized 21, Birtle R. 19, Silver Creek 19, Beausejour 17, Hanover 16, Kildonan West 15, Brooklands 12, St. Boniface 12, Dauphin T. 11, Kildonan East 10, Emerson 7, Kildonan North 6, Morden 6, Gimli 4, Shellmouth 4, Ste. Anne 4, Ethelbert 3, Macdonald 3, Rossburn R. 3, Russell T. 3, Winnipeg Beach 3, Roblin R. 2, Transcona 2, Brandon 1, Cypress N. 1, Franklin 1, Hamiota R. 1, Lac du Bonnet 1, Oakland 1, Stanley 1, Swan River R. 1, St. Andrews 1, Teulon 1. Delayed reporting — April: Unorganized 1; May: Wawanesa 4.

Chickenpox: Total 164 — Winnipeg 96, St. Boniface 14, Unorganized 9, Springfield 9, Dauphin T. 7, Oakland 6, Silver Creek 5, Whitehead 4, Selkirk 3, Brandon 2, Brooklands 2, Norfolk North 2, Pipestone 2, Argyle 1, Strathclair 1, St. Vital 1.

Whooping Cough: Total 80—Macdonald 50, St. Andrews 4, Winnipeg 4, Whitemouth 3, North Cypress 2, Dauphin Town 2, Hanover 1. Late reported — March: Fort Garry 6; April: Fort Garry 7; May: Fort Garry 1.

Tuberculosis: Total 76—Winnipeg 22, Unorganized 4, Dauphin R. 3, Brandon 2, Springfield 2, Swan River R. 2, St. Clements 2, St. James 2, Transcona 2, Armstrong 1, Birtle T. 1, Blanchard 1, Carman 1, Cypress South 1, Ellice 1, Elton 1, Flin Flon 1, Fort Garry 1, Gilbert Plains V. 1, Hanover 1, Kildonan West 1, Louise 1, Manitou 1, Minnedosa 1, Morris R. 1, Morton 1, North Norfolk 1, Odanah 1, Pembina 1, Rockwood 1, Selkirk 1, Shellmouth 1, Sifton 1, Strathclair 1, Strathcona 1, Swan River T. 1, St. Andrews 1, St. Boniface 1, St. Francois 1, St. Vital 1, Tuxedo 1, Westbourne 1, Whitemouth 1, Winnipegosis 1.

Scarlet Fever: Total 64—Winnipeg 28, St. Boniface 9, St. Andrews 5, Kildonan East 5, Cypress North 2, Kildonan West 2, Stonewall 2, Carman 1, Dauphin T. 1, Minitonas 1, Rockwood 1, Springfield 1, St. Vital 1, Thompson 1, Transcona 1, Tuxedo 1, Unorganized 1. Late reported—May: St. James 1.

Mumps: Total 36 — Winnipeg 31, Brooklands 2, Dauphin R. 2, Emerson 1.

Diphtheria: Total 22 — Winnipeg 17, Macdonald 2, Thompson 2, Piney 1.

Erysipelas: Total 7—Winnipeg 5, St. James 2.

Influenza: Total 2 — Late reported — May: Kildonan East 1, Portage City 1.

Typhoid Fever: Total 1—Kildonan East 1.

Diphtheria Carrier: Total 1—Winnipeg 1.

Venereal Diseases: Total 139—Gonorrhoea 92, Syphilis 47.

DEATHS FROM ALL CAUSES IN MANITOBA, for the Month of April, 1934:—

URBAN—Cancer 17, Pneumonia (all forms) 9, Tuberculosis 10, Influenza 2, Measles 2, Diphtheria 1, all other causes under one year, not included elsewhere 20, all other causes 111, Stillbirths 16. Total 188.

RURAL—Cancer 28, Tuberculosis 25, Pneumonia (all forms) 19, Influenza 9, Whooping Cough 3, Scarlet Fever 1, all other causes under one year, not included elsewhere 31, all other causes 116, Stillbirths 22. Total 254.

INDIANS—Pneumonia (all forms) 8, Tuberculosis 6, Diphtheria 1, Puerperal Septicaemia 1, all other causes under one year, not included elsewhere 3, all other causes 9, Stillbirths 2. Total 30.

College of Physicians and Surgeons of Manitoba

ELECTION OF COUNCIL

NOMINATIONS for election to the Council of the College of Physicians and Surgeons of Manitoba will be held in August. Voting will take place in September. Any member of the College of Physicians and Surgeons in Manitoba not in good standing, or whose fees have not been paid, will not be allowed to stand for election, to propose or second a nomination, or to vote in the election of the Council.

—W. G. Campbell.

News --- Notes --- Correspondence

By Ross Mitchell

(SIR) GEORGE SIMPSON AND DR. McLOUGHLIN

In the fall of 1824 George Simpson, not yet Sir George, was travelling furiously as was his wont, driving his men to the utmost, westward on the way to the Oregon. On the upper Saskatchewan he overtook Dr. John McLoughlin and his heavier laden party, and the two travelled together to the Oregon. This was the Doctor's first sight of the future home in which he was to be a very dominating figure. As a result of Simpson's visit Fort Vancouver was built and the Doctor put in charge, the beginning of a very notable career as trader, administrator, pioneer and father of a new bit of country.

The meeting on the Saskatchewan Simpson describes as follows:

"On the 26th at 7 o'clock a.m. came up with the Doctor (McLoughlin) before his people had left their Encampment. . . Himself and his people were heartily tired of the voyage . . . He was such a figure as I should not like to meet in a dark Night in one of the bye lanes in the neighborhood of London, dressed in Clothes that had once been fashionable, but now covered with a thousand patches of different Colors. His beard would do honor to the chin of a Grizzly Bear, his face and hands evidently shewing that he had not lost much time at his Toilette. loaded with Arms and his own herculean dimensions Forming a tout ensemble that would convey a good idea of the high way men of Former Days."

A few days later:

"Being extremely unwell for some time past I was rocemmended by Dr. McLoughlin to lay by the remainder of the Day in order to benefit by his professional skill, which I accordingly did and experienced much benefit therefrom."

* * *

THE LADY WINS

"Fur Trade and Empire"—George Simpson's Journal, 1824-25.

(Edited by Prof. Frederick Merk) Published by Harvard University Press, 1931. Page 164.

Simpson was very anxious to go to England in fall of 1825 and thought that meant that Governor Pelly (Governor of Red River) should stay. He thought both couldn't be absent together. So he pressed Pelly:

"As I anticipated Gov. Pelly could not give me the meeting I requested at Norway House owing to Mrs. Pelly's delicate state of health, and had determined on returning to England with his family by the fall ship. I pointed out to him the necessity of my going home for the purpose of communicating with the Honble. Committee on business by showing him my Columbia dispatch but his mind was unalterably made up, Dr. Hamlyn having intimated that if Mrs. Pelly did not go to England this season for the benefit of medical advice her life was in danger, but if that was saved it was more than probable she would be attacked with palsy and not only lose her corporal but mental faculties. Dr. Hamlyn, moreover, stated that he did not think Mrs. Pelly could with any degree of safety undertake the voyage unless attended by Gov. Pelly, and these statements he made to me in his professional capacity in the presence of Gov. Pelly. Under those circumstances they take their departure from hence for York about the 20th July."

Both Simpson and Pelly went over and MacKenzie ruled in their stead.

Note:—For these articles we are indebted to Dr. D. A. Stewart.

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Fifty-five Years Ago— July 16, 1879.

There were now ten patients in the Winnipeg General Hospital; typhoid fever had been prevalent in Winnipeg.—The steamer Manitoba, one of the finest of the Red river fleet, arrived with 90 passengers; among them were included the Archbishop of Rupert's Land and Rev. O. Fortin, of Holy Trinity.

—*Manitoba Free Press.*

Medical Library University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. HOLLAND, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

"THE MEDICAL JOURNAL OF AUSTRALIA"

"A Report on Thirty Cases of Evipan - Sodium Anæsthesia" — by J. S. MacMahon and E. G. MacMahon, Sydney.

—A discussion of the use of Evipan with results obtained. These observers conclude that Evipan is a useful drug for minor surgical procedures. It is not suitable for abdominal operations.

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"THE BRITISH MEDICAL JOURNAL"

June 16th, 1934.

"Pregnancy Diagnosis in Theory and Practice" —by J. M. Robson, M.D., M.Sc., Beit Memorial Research Fellow.

—A report of results obtained in tests for the presence of gonado-tropic hormones in the urine. The Friedman and the Ascheim-Zondak tests are compared and found to be about equally reliable—both tests giving over 98% accuracy.

"Hypertonic Rectal Saline for Intracranial Injury in the New Born"—by Alan Monerief, M.D., F.R.C.P., London.

—A bulging fontanelle becoming normal, a comatose baby coming out of coma and taking feeds normally, and the cessation of twitching and cyanotic attacks are some of the impressive results obtained by this treatment.

"Duodenal Ulcer in a Ten-Year-Old Child"—by M. Brice Smyth, P. T. Crymble and F. M. Allen, Belfast.

—This case treated by posterior gastro-enterostomy with relief of symptoms.

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"THE BRITISH MEDICAL JOURNAL"

June 2nd, 1934.

"Renal Glycosuria Mistaken for Diabetes Mellitus"—by R. D. Lawrence, M.D., F.R.C.P., and R. A. McCance, M.D., Ph.D., The Diabetic Clinic, King's College Hospital.

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"THE CANADIAN MEDICAL ASSOCIATION JOURNAL"—July, 1934.

"Staphylococcus Anti toxic Serum in the Treatment of Acute Staphylococcal Infections and Toxæmias"—by C. E. Dolman, M.B., M.R.C.P., Connaught Laboratories, Toronto.

—The second of a series of articles on the results with use of anti toxic serum in staphylococcic infections. This paper deals with cases in which no staphylococcaemia is demonstrable.

"The Early Diagnosis of Cancer of the Breast" —by E. M. Eberts, Montreal.

—This article well illustrated by case histories and micro-photographs is the eleventh paper in the series on the early diagnosis of cancer.

"The Injection Treatment of Hæmorrhoids"—by H. Gurth Pretty, M.D., Montreal.

"Chronic Arthritis Treated by Crowe's Vaccine" —by J. A. Mutter, M.D., and E. R. Watson, M.D., Montreal.

"Hiccup"—by E. Clark Noble, M.B., M.R.C.P., Toronto.

"The Use of Caudal Anæsthesia in Urology and Proctology"—by Vincent F. Onhauser, M.D., Winnipeg.

—This paper gives the technique of the method in detail and a large number of case reports are included.

"Chorea Gravidarum, With the Report of a Case"—by S. Kobrinsky, M.D., Winnipeg.

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"THE NEW ENGLAND JOURNAL OF MEDICINE"—July 5th, 1934.

"The Menace of Diabetic Gangrene"—by E. P. Joslin, M.D.

—A very good article on the subject.

"Liver Abscess—A Review of Eighty-Five Cases" —by Chester S. Keefer, M.D.

"Endometrioma of Bartholin's Gland" — by Christopher J. Duncan, M.D.

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"THE CLINICAL JOURNAL"—July, 1934.

"Chronic Swellings in the Neck" — by Zachary Cope, M.D., F.R.C.S.

"Common Injuries to Joints of the Fingers and Wrists"—by St. J. D. Buxton, F.R.C.S.

"So-Called Mucous Colitis"—by Arthur F. Hurst, M.D., F.R.C.P.

"The Reaction of the Constitution in Therapy" —by T. E. Hammond, F.R.C.S.

—A long article on the constitutional results of various methods of treatment.

"Immunization in Measles, Diphtheria and Scarlet Fever" — by David Nabarro, M.D., F.R.C.P.

"The Practitioner's Care of Insulin Diabetics in Routine and Emergencies"—by R. D. Lawrence, M.D., F.R.C.P.

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"THE LANCET"—July 7th, 1934.

"Principles of X-Ray Therapy of Malignant Disease"—by Henri Cantard, M.D., Chief of the Dept. of X-ray Therapy for Cancer, Radium Institute of the University of Paris.

—An excellent article well illustrated by radiograms and photographs

"The Dangerous Multipara" — by Bethel Solomons, M.D., F.R.C.P. (Ireland), Late Master of Rotunda Hospital, Dublin.

"Psychological Effects of Bodily Illness in Children"—by David Forsyth, M.D., F.R.C.P.